Kansas Prescription Drug Monitoring Program
Advisory Committee
Legislative Report

Prepared by the

Kansas Prescription Drug Monitoring Program
Advisory Committee
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1. Executive Summary

The 2008 Legislature passed legislation (SB 491) that charged the Kansas Board of Pharmacy with creation of a prescription monitoring program (PMP). The legislation created a multi-stakeholder PMP Advisory Committee to oversee the PMP. During 2008, the PMP Advisory Committee explored other states' PMP programs, issues, and the challenges states face in administering their PMPs, and developed draft rules and regulations with input from a variety of stakeholders impacted by this legislation. This report details the work of the PMP Advisory Committee, information obtained from other state PMPs, including in-depth information from interviews with five other states, lessons learned from other states, and feedback from stakeholder groups.

Finally, based on the research completed by the PMP Advisory Committee during 2008, this report provides the Committee's recommendations to the Legislature on the implementation, administration, maintenance, and funding of the Kansas PMP.

2. Background

The 2008 Legislature passed SB 491- legislation that called for the Board of Pharmacy to create a PMP, and established a PMP Advisory Committee to assist with the development and oversight of the PMP.

This report has been prepared for the Senate Standing Committee on Public Health and the House Standing Committee on Health and Human Services, as required in statute. The purpose of this report is to provide a detailed and comprehensive review of a PMP, to report on work completed by the PMP Advisory Committee, and provide the committees' findings and recommendations to the Senate and House Committees for the Kansas PMP.

Included in this report is background information on the Kansas PMP, entities responsible for the development and maintenance of the Program, operation and use of the Program, related information concerning national perspectives on PMPs, and recommendations for future plans and considerations.

3. Diversion of Controlled Pharmaceutical Substances

3.1 Overview of National Data

Abuse and diversion of controlled pharmaceutical substances has risen significantly in the United States over the last several years. In July 2005, the National Center for Addiction and Substance Abuse at Columbia University (CASA) published *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S.* Figure 1 from this report illustrates the increase in controlled substance abuse compared with the increase in the U.S. population as reported by CASA.

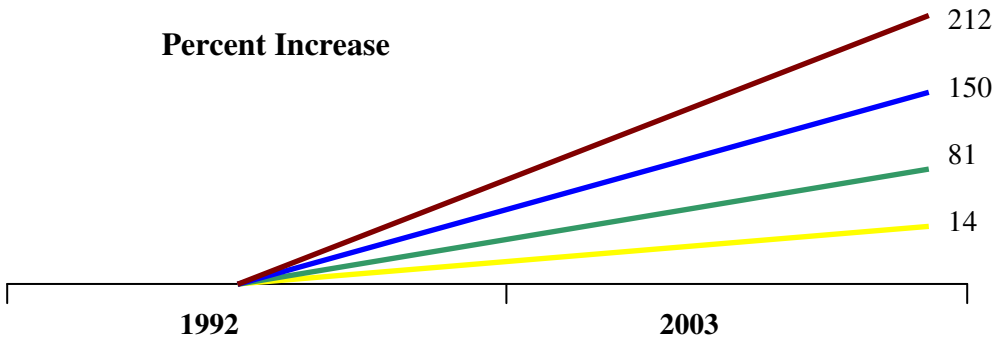

Figure 1 - Controlled Substance Abuse

While the U.S. population increased 14% from 1992 through 2003, during this period, the number of adults 18 and older abusing controlled prescription drugs increased 81%. The number of 12 to 17 year olds abusing such drugs increased 212%.

Abuse of prescription drugs has exceeded that of illegal substances in many cases. The CASA study revealed that in 2003, 15.1 million Americans abusing prescription drugs exceeded the number of Americans abusing cocaine (5.9 million), hallucinogens (4.0 million), inhalants (2.1 million) and heroin (.3 million) combined.

The impact of prescription drug misuse and abuse is not limited to the person abusing or addicted to prescription drugs or their family. The Council of State Governments published a report in April 2004 that indicated during 2001, the costs to the health care system for prescription drug misuse and abuse were estimated at $100 billion annually.[1] As policymakers examine funding for health programs, a focus on how PMP programs can reduce controlled substance misuse, inform practitioners by providing them information related to controlled substance utilization by there patients, and increase patient safety as a result is extremely important. It is hoped that enhanced provider education regarding pain management, improved patient safety and a reduction in inappropriate utilization of controlled substances can help control related health care costs.

Healthcare providers consistently report a number of barriers that prevent them from providing optimal pain management to their patients. Among these barriers is a concern about patients who may be engaging in behavior known as "doctor shopping", wherein they see multiple prescribers without informing those providers, in an effort to obtain multiple prescriptions for purposes of abuse or diversion. Another commonly cited barrier is the concern about regulatory scrutiny. Prescribers are concerned that legitimate efforts to manage their patients' pain may be misconstrued by regulatory boards or law enforcement agencies as drug dealing, which may subject them to unwanted, costly, and time-consuming investigations and, potentially, loss of their medical license and DEA registration, effectively putting them out of business. Reports of studies such as those cited above serve to heighten these fears, as prescribers are well aware of the apparent increase in the magnitude of this problem.

A key recommendation from the CASA study was that the U.S. Department of Justice and the Food and Drug Administration fund the development of model state legislation for state PMPs and provide financial incentives for states to develop and operate PMPs in accordance with national standards. Model state legislation was developed, and there have been limited federal funds available to states through the Bureau of Judicial Assistance. Kansas applied for, but did not receive, federal grant funding for implementation of the PMP in 2008. The Kansas Board of Pharmacy plans to re-apply for federal grant funding in 2009 that would assist with funding the implementation of Kansas' PMP.

3.2 The Importance of a PMP for Kansas

Law enforcement and health agencies throughout Kansas recognize the abuse and diversion of controlled substances as an increasing threat. This type of abuse makes it more difficult for

[1] The Council of State Governments Web Site, Drug Abuse in America-Prescription Drug Diversion Trends Alert, April 2004, available at www.csg.org/pubs/Documents/TA0404DrugDiversion.pdf

individuals in pain to obtain appropriate pain management, and for their treating physicians and other prescribers to comfortably prescribe appropriate treatment.

Due to the subjective nature of pain, it is necessary for healthcare providers to rely on patients' self-reports of their pain experience in order to gauge the effectiveness of their treatments. This requires that healthcare providers trust their patients' reports of pain in order to design a treatment regimen. Unfortunately, there is a relatively small percentage of the general population (estimated to be about 10-15%) that carries a second diagnosis, one of addictive disease (substance abuse), some of whom are less than honest in their reports of pain, as a means of obtaining drugs for the purpose of abuse.

While it is possible to adequately manage pain, even using opioid medications, in these patients, it is a major management challenge requiring great skill on the part of healthcare providers. Healthcare providers generally are poorly trained to recognize and treat both pain and addictive disease. As a consequence, many feel acutely uncomfortable when confronted by patients with either diagnosis, and will, to some extent, opt to avoid or minimize treatment whenever possible. Repeated reports of an increasing prevalence of drug abuse serve to heighten these concerns and further reduce the willingness of healthcare providers to treat pain.

As a result, it is important that in addition to the role of providing prescribers and dispensers with controlled substance utilization information for their patients, Kansas' PMP work collaboratively with the medical community to provide pain management education to health care providers.

Prescription Drug Abuse

According to drug industry sales figures, use of pain relievers and mood enhancers, which are often addictive and often the drugs of choice for first-time abusers, is increasing. Drug Enforcement Administration (DEA) officials testifying before Congress earlier this year described the increase in the use of pain relievers and mood enhancers as alarming.[2] More than 7 million Americans abuse prescription drugs, according to the DEA, an 80 percent increase in six years. Figures for Missouri and Kansas suggest abuse may be especially pronounced here. State officials say they lack the tools available in most other states to deal with it. Federal figures show that shipments into Kansas of hydrocodone (the active ingredient in Vicodin, the most-commonly abused opioid medication, and the most-commonly prescribed medication in the United States) jumped by more than 300 percent since 2000, much in the last year. Oxycodone, another commonly abused synthetic opioid, is up more than 260 percent.[3] (Note that these numbers generally reflect national usage trends.) OxyContin continues to be a pharmaceutical drug of choice in the state of Kansas, for illicit use.[4] Its users favor it over street drugs such as heroin due to the consistent purity and quality. Other substances cited include: benzodiazepines, meperidine, hydromorphone, methylphenidate and morphine. [5]

[2] Mcgraw, Mike. "Prescription Drug Abuse Rises in Recession." Kansas City Star 30 Dec. 2008
[3] Id.
[4] U.S. Drug Enforcement Administration Web site, DEA Briefs & Background, *State Fact Sheet – Kansas 2008*
[5] Id.

Diverted pharmaceuticals pose a significant and increasing threat to Kansans. Data on utilization of these medications is required by statute to be reported to the PMP. The diversion of prescription drugs for illicit use is a threat not only to our state's citizens but is a burden on law enforcement resources. The investigations into the diversion of these medications take special expertise that is often not found in many Kansas law enforcement agencies. With the violence associated with illegal drugs such as methamphetamine, cocaine, and heroin Kansas law enforcement resources to address the increasing abuse of prescription medications are limited.

A PMP program will assist legitimate prescribers by providing them data to determine if, or ensure that, their patients are not receiving controlled substances from multiple prescribers, "doctor shopping", or over-utilizing controlled substances. A PMP assists the pharmacy by providing the pharmacist access to data to ensure that the patient has not previously filled a prescription being presented or that the patient is not visiting numerous pharmacies with similar prescriptions from multiple doctors. The program provides data to health care practitioners that they can access before prescribing or dispensing controlled substances and enables them to better ensure appropriate use. By providing access to these data on-line, the PMP can help to prevent or stop criminal activity related to controlled substance abuse, while improving pain management and the treatment of addictive disease.

Clearly the PMP is a potent tool and the providers of the state will accept this program as a valuable aid in their daily medical practices.
In regards to the providers:

1. The PMP will add transparency to the treatment of chronic pain patients. Patients and providers can agree to therapeutic contracts with openness and honesty. The ability to verify the therapeutic use of these powerful medications will only serve to strengthen legitimate pain patient treatment contracts.
2. The educational aspect of the PMP will improve the treatment of chronic pain and increase the access of patients to providers willing to manage their pain needs. It was reported to the PMP Advisory Committee that there has been a definite chilling effect in the past two years among physicians in Wichita willing to manage pain patients. This fear resulted in access problems for legitimate chronic pain patients. By working collaboratively with the professional associations for pharmacists, physicians, and other prescribers, the PMP can provide enhanced educational activities and will improve the effectiveness of the treatment and access of pain patients.
3. The PMP has the potential to empower physicians and pharmacists to be agents of change to slow the unauthorized use of controlled substances by identifying the patient who might be showing drug seeking behavior. This early and verifiable observation will allow for rapid medical intervention for patients at risk. Used as a verification tool, the provider will be able to serve the chronic pain patient with more confidence and greatly reduce the risk of having a prescription diverted for illegal use.

Finally, the PMP represents a collaboration of very unlikely partners for the advancement of the health of our Kansas citizens. The interaction of law enforcement officers, pharmacists, legislators, and physicians for the greater good is heartening. This shows that good people can bring their collective skills together for the creation of project that improves the health and safety of Kansans.

4. Creation of the Kansas Prescription Monitoring Program

4.1 Prescription Monitoring Programs

Prescription Monitoring Programs are designed to help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists. States that have implemented PMPs have the capability to collect and analyze prescription data much more efficiently than states without such programs, where the collection of prescription information requires the manual review of pharmacy files, a time-consuming and invasive process. The increased efficiency of PMPs allows for the early detection of abuse trends and possible sources of diversion.

The purpose of the program is not to restrict the availability of controlled substances, but to ensure integrity in health care by providing prescribers and pharmacies with information on their patients to ensure legitimate use. It is important that the program be used to improve pain management and the detection and treatment of addictive disease. A secondary purpose of these programs is to enhance the capacity of regulatory and law enforcement agencies to collect and analyze controlled substance prescription data by building a data collection and analysis system at the state level, enhancing existing programs' ability to analyze and use collected data and facilitate the exchange of collected prescription data among states.

In 2008 the number of states with legislation authorizing the establishment and operation of a state PMP is 38. Of those 38 states, 32 of those programs are currently operating and 6 are in the start-up phase. Differences among PMPs include restrictions on who may be authorized to access the data (e.g., some states limit to law enforcement only), and the scheduled controlled substances covered (e.g., some states include schedule II drugs only; some such as Kentucky include schedules II – V). Appendix A identifies those states that currently have implemented a PMP and Appendix B, *Status of State Prescription Monitoring Programs,* contains some basic PMP status information for each state including ownership of the program, schedules covered, and when the data collection was started in those states. Eleven states are in the process of proposing, preparing, or considering legislation to start a PMP. These states include Arkansas, Delaware, Florida, Georgia, Maryland, Missouri, Montana, Nebraska, New Hampshire, Oregon, and South Dakota. Only one state (Wisconsin) and the District of Columbia have done nothing to implement a program.

4.2 Development of the Kansas Program - Senate Bill 491

Senate Bill 491 created the Prescription Drug Monitoring Act. The bill, which can be found in Appendix C, requires the Board of Pharmacy to establish and maintain a program for monitoring controlled substances. The Board is required to develop rules and regulations that govern and carry out provisions of this act, as well as develop an electronic database to which prescribers or pharmacists who distribute prescriptions can submit information regarding each prescription dispensed. All information in the prescription monitoring database and any records pertinent to the program will remain confidential and are not subject to the Kansas Open Records Act.

Senate Bill 491 also created the Prescription Drug Monitoring Advisory Committee, which will work in consultation with the State Board of Pharmacy to ensure effectiveness of the program and create continuing education programs concerning the purposes and use of the PMP. The Advisory Committee will be responsible for submitting an annual report to the Senate Committee of Public Health and Welfare and House Committee on Health and Human Services.

5. Prescription Monitoring Program (PMP) Advisory Committee Work

5.1 PMP Advisory Committee Membership

Shortly after the passing of Senate Bill 491, the Kansas State Board of Pharmacy mailed nomination letters to organizations who were to be included in the Prescription Drug Monitoring Advisory Committee. The Committee consists of:

1. Two licensed physicians, one nominated by the Kansas Medical Society, and one nominated by the Kansas Association of Osteopathic Medicine;
2. Two licensed pharmacists nominated by the Kansas Pharmacists' Association;
3. One person representing the Kansas Bureau of Investigation nominated by the Attorney General;
4. One person representing the University of Kansas School of Medicine nominated by the Dean of the School;
5. One person representing the University of Kansas School of Pharmacy nominated by the Dean of the School;
6. One licensed dentist nominated by the Kansas Dental Association;
7. One person representing the Kansas Hospital Association nominated by such association; and
8. The Board may also appoint other persons authorized to prescribe or dispense scheduled substances and drugs of concern, recognized experts, and representatives from law enforcement.

Please see Exhibit D for the Kansas Prescription Monitoring Advisory Committee Membership Listing.

5.2 PMP Advisory Committee Meetings

Shortly after the Advisory Committee was formed, the first meeting was held on September 12th. At this meeting, Karen Braman, R.Ph.,M.S. presented a PowerPoint presentation regarding the specific requirements of SB 491. She was also nominated and selected to serve as the Advisory Committee Chairperson. The group discussed drugs of concern that should be included in the regulatory process. There was discussion about Committee membership and if additional expertise is needed. The group agreed that since the PMP database will contain all Schedule II – IV and drugs of concern prescriptions, including prescriptions paid for by Medicaid. Since Medicaid information will be collected the Kansas Health Policy Authority should have access to PMP records for Medicaid consumers, a representative from KHPA should serve on the Committee. LeAnn Bell was later nominated by KHPA to serve as its representative on the Advisory Committee. In addition, the Committee decided it would be very beneficial to interview a few other states regarding the implementation and maintenance of a Prescription Drug Monitoring Program

Following the meeting, Board of Pharmacy Staff collected rules and regulations from five other states that have PMPs in operation. The states that were chosen were Kentucky, Virginia, Colorado, Ohio, and Maine. Further, a matrix of questions was developed for interviews of these states. See Appendix E for the interview matrix. Phone conferences were held with a representative of each of these states in order to gain further insight into the lessons learned in implementing each of these states' PMPs. During this time, Board of Pharmacy staff and Chairperson Karen Braman met with the Board's attorney to begin drafting regulations for the Prescription Drug Monitoring Program. These draft regulations can be found in Appendix G.

The second Advisory Committee Meeting was held on October 9th, 2008. At this meeting, Karen Braman presented an overview of interviews conducted with five states regarding their PMPs. The information shared from other states included implementation process, costs, staffing and resource requirements, software and hardware requirements, stakeholder community acceptance and education, analysis and use of the data, lessons learned and future planning. In addition, Karen Braman suggested forming a subcommittee to begin working on the January 2009 report to the Legislature. The group also discussed bringing representatives of another state's Prescription Drug Monitoring program to present an in-depth look at their Prescription Drug Monitoring programs. The group also discussed the draft regulations that were created for the Kansas Program.

After the October Meeting, Advisory Committee Member Jeff Brandau arranged a visit from representatives of the Virginia Prescription Drug Monitoring Program. The Virginia representative was scheduled to meet with the Kansas Advisory Committee on December 12th, 2008.

At the December Meeting, Karen Braman gave a brief overview of what Kansas has been doing to implement a PMP. Jeff Brandau, with the Kansas Bureau of Investigation, also presented statistics on nationwide and local prescription drug abuse and the importance of implementing a PMP. The remainder of the meeting was set aside for a representative from Virginia to present on Virginia's PMP. He gave a Program Overview and Demonstration and spoke about issues such as data and analytics, education programs and services, staffing levels, budget, funding sources, and lessons learned. He also took time for questions at the end of the meeting.

PMP Advisory Committee Meeting Minutes are located in Appendix F.

6. Program and Project Support for the Kansas Program

The cost of implementing and operating a PMP differs from state to state because of many variables that exist across geography, types of practice, stakeholder participation, technology available at time of implementation, and funding levels. The average cost to implement a PMP over the last several years was reported by states as approximately $350,000. State annual operating costs for PMPs range from $100,000 to nearly $1 million. Cost variations are affected by the frequency of data collection (daily, bi-weekly vs. monthly), the use of third party vendors for data collection and analysis, the number of prescriptions written/filled in a state, the number of schedules (II-V) collected, and the use of official forms when required.

The Kansas PMP is currently unfunded. This is the greatest obstacle for implementation. After interviewing other states, our Advisory Committee found that other states' Programs have been funded in various ways: appropriated state funds, settlement money received from the states' Attorney General, professional licensing fees, and through the federal Harold Rogers Grant program.

The Kansas Board of Pharmacy applied for a $400,000 Harold Rogers Implementation Grant in February of 2008 for fiscal year 2009. In October of 2008, the Pharmacy Board received notice that Kansas was not awarded the grant. The primary reason provided by grant reviewers for not funding Kansas' application was that there was not legislation in place at the time that the grant application was submitted. Please see Appendix H for feedback from the Department of Justice on Kansas's FY 2008 Harold Rogers Grant Application.

The Kansas State Board of Pharmacy has obtained copies of the two successful Implementation Grant applications for Fiscal Year 2008 (Guam and Minnesota) and plans to submit another grant application in 2009.

6.1 Harold Rogers Grant

In FY 2002 the U.S. Department of Justice Consolidated Appropriations Act (Public Law 107-77) created a grant program entitled Developing and Enhancing Prescription Drug Monitoring Programs. The grants have become known as the Harold Rogers Grants, in honor of primary sponsor of the act, Congressman Harold (Hal) Rogers from Kentucky's 5th Congressional

District. The Bureau of Justice Assistance administers this program with the U.S. Drug Enforcement Administration (DEA), Office of Diversion Control and the Office of National Drug Control Policy (ONDCP).

The primary purpose of the grant program is to enhance the capacity of regulatory and law enforcement agencies to collect and analyze controlled substance prescription data through a central database administered by an authorized state agency. The program focuses on providing help for states that want to establish a PMP and to help states with existing PMPs to improve the efficiency and effectiveness of the program.

Program objectives include:

- Building a data collection and analysis system at the state level.
- Enhancing existing programs' abilities to analyze and use collected data.
- Facilitating national evaluation efforts.
- Encouraging the exchange of information and collected prescription data among states.
- Assessing the efficiency and effectiveness of programs funded under this initiative.
- Enhancing collaborations with law enforcement, prosecutors, treatment professionals, the medical community, and pharmacies.

States may submit a grant application in one of three categories:

- CATEGORY I: PLANNING. Grant maximum: $50,000. Project period: 15 months.
  -States without a PMP may apply for a planning grant, and need not have legislation or regulations pending or in place.

- CATEGORY II: IMPLEMENTATION. Grant maximum: $400,000. Project period: 24 months.
  -States that have in place or pending legislation or regulations that require the submission of dispensing data to a centralized database *and* authorize and/or designate a state agency to provide program oversight and implementation may apply for an implementation grant. States developing a voluntary pilot program also may apply for an implementation grant. Funds may be used to plan, establish, and build a data collection and analysis system; develop an infrastructure to support programmatic activities; facilitate the exchange of information and collected prescription data among states; facilitate the establishment of collaborations; produce and disseminate educational materials; and assess the efficiency and effectiveness of the program.

- CATEGORY III: ENHANCEMENT. Grant maximum: $400,000. Project period: 24 months.
  -States seeking to improve existing PMPs for diversion efforts are eligible to apply for an enhancement grant. Funds may be used to enhance a data collection and analysis system; develop infrastructure to support programmatic activities; support collaborations with law enforcement and prosecutors; facilitate information sharing among states; and assess the efficiency and effectiveness of

the program. Enhancement applications should not be used to chiefly support core programmatic activities.

State governments are eligible for grant funds if they have in place or pending an enabling statute or regulation that requires the submission of controlled substance prescription data to a centralized database administered by an authorized state agency. The legislation or regulations should include:

- The required submission of data for prescriptions in Schedules II, III, IV, and V.
- The submission of data elements consistent with standards established by the American Society for Automation in Pharmacy.
- Access to collected data by federal, state, and local law enforcement personnel statutorily authorized to access prescription data by traditional, manual methods.

It is important to note that the federal grant funds are limited. If Kansas is successful in obtaining a Harold Rogers grant, the grant will assist with implementation costs of the PMP program, but can not be relied upon for continued maintenance funding of the program.

6.2 State Settlement Money

A few Prescription Drug Monitoring Programs are funded through settlement money received by their respective states. For example, the State of Virginia received Prescription Drug Monitoring Funding through the Purdue Frederick settlement related to inappropriate marketing of Oxycontin. The Virginia PMP did not ask to be included in the settlement but the Virginia Attorney General's office included the program determining this was an appropriate use of these settlement funds. Connecticut's PMP recently received $100,000 from a settlement with the pharmaceutical manufacturer Cephalon.[6] The State of Maine's Program is funded through State Tobacco Settlement money.

6.3 Appropriated State Funds

Many other states' Prescription Drug Monitoring Programs are state funded. Some states provide for the collection of a fee from an individual who holds a license that authorizes him or her to prescribe a controlled substance, if the state appropriations for the direct or indirect costs of the program are insufficient to maintain the program. These fees are collected in conjunction with license renewal fees. SB 491 prohibits the Board of Pharmacy from charging prescribers or dispensers for the program. Kentucky receives state funding for the administration of their PMP. They have received approximately $5 million over the last two years to continue their program and will receive an estimated $1.4 million from their Legislature next year.

[6] Connecticut Attorney General's Office Press Release, May 8, 2008, available online at http://www.ct.gov/ag/cwp/view.asp?A=2788&Q=379606

7. Recommendations

7.1 Funding

The Board of Pharmacy should reapply for the Harold Rogers Grant to assist with implementation of the PMP program. Grant funding can not be relied upon for continued program administration. It is strongly recommended that state policy makers, including the Legislature and the Board of Pharmacy plan now for continued funding of the program once established.

7.2 Program Implementation

Once funding is obtained, the Board of Pharmacy should issue a request for proposal (RFP) describing the requirements needed for a Kansas PMP. Once a vendor(s) is selected, implementation should begin with oversight of the established board. An education program, as specified in SB 491 should include information on the use of PMP as well as how to reduce the diversion of scheduled medications. The committee would like to include some basic pain management assessment/treatment information as well as some addiction assessment/treatment information. The educational program should be developed in conjunction with the health care community, through the respective professional associations. According to other states, the implementation period will vary and can last up to 12 months. It is important that the Board of Pharmacy and PMP communicate to health care providers regarding the status of the program and required data submission.

7.3 Program Administration and Maintenance

Implementation and management of the PMP will require additional staff and space within the Board of Pharmacy. Other states interviewed responded that they have from three to fourteen additional staff to manage their respective PMPs. Space is currently limited at the Board of Pharmacy. Additional space will be needed for program staff as well as secured servers that will store the PMP data. It is suggested that a third party vendor be contracted to assist with technical and data-related aspects of the program and this should be included in the RFP.

7.4 Review of Kansas Law to Determine if Barriers Exist to Health Information Exchange through the PMP

The PMP program involves the exchange of health information. Pharmacies will be submitting prescription drug utilization data to the PMP. Prescribers and dispensing pharmacies will access this information for the care of their individual patients. It is recommended that a review of

health law in Kansas be conducted to determine if any barriers to the timely and appropriate exchange of this information exists. Exchange of information through the PMP will be conducted intra-state, as well as inter-state. The Kansas City metropolitan area is a good example of a bi-state metropolitan area where patients seek care across state lines on a regular basis. A review of any issues regarding sharing this data across state lines with other PMP programs should be conducted.

There has been work on-going regarding health information exchange (HIE) and health information security and privacy through a number of statewide initiatives. Most recently the Kansas legal workgroup of the national Health Information Security and Privacy Collaborative (HISPC) developed a tool and narrative guide to help examine Kansas health law and prioritize any changes needed to law to enable HIE in Kansas. The state of Missouri is also using this tool. The PMP is an example of a program that could potentially benefit from use of this tool and examination of law to enable successful, appropriate exchange of health information.

8. Conclusion

There is an abundance of reasons why Kansas is one of the many states to enact a Prescription Monitoring Program. The emerging challenge of prescription drug abuse and misuse is a complex issue that requires a concerted effort by all Kansans. The Kansas PMP, along with treatment and prevention programs that include outreach and education, is a key part of responding to this issue. The resulting impact of reducing diversion of controlled substances will also assist law enforcement and benefit the state. In addition, the Kansas PMP will provide valuable and much needed data to health care providers and enhance their ability to manage chronic pain. In doing so, the benefits will be passed on to the residents of Kansas who are the patients of these health care providers. It is a cycle that will continue to benefit Kansans for years to come.

The Committee Members appreciate the opportunity to serve on the PMP Advisory Committee and respectfully submit this report to the Senate Standing Committee on Public Health and the House Standing Committee on Health and Human Services.

9. Appendix Listing

A. Status of State Prescription Monitoring Programs Map
B. Status of State Prescription Monitoring Programs Information Page
C. Senate Bill 491
D. Kansas Prescription Monitoring Advisory Committee Membership Listing
E. Matrix
F. Meeting Minutes
G. Draft Regulations
H. Grant Application Feedback from DOJ